Emergency Care Plan for Child with Severe Allergies

Child's Name:______________________________ Date of Birth:______________________

Allergies:____

Signs of an allergic reaction include:

Systems:	Symptoms:
Mouth	Itching & swelling of the lips, tongue, or mouth
Throat*	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
Skin	Hives, itchy rash, and/or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung*	Shortness of breath, repetitive coughing and/or wheezing
Heart*	"weak" pulse, loss of consciousness

The severity of symptoms can quickly change.

***All above symptoms can potentially progress to a life threatening situation!**

Place Child's Photo Here

TO BE COMPLETED BY HEALTHCARE PROVIDER

If reaction is suspected give **IMMEDIATELY**:

Treatment prescription:______________________________ Dosage:______________________

For the described **symptoms**:____

Treatment prescription:______________________________ Dosage:______________________

For the described **symptoms**:____

Precautions and/or possible adverse reactions:____

Contact emergency medical services *whenever* epinephrine is used. *A single dose of epinephrine wears off in 15-20 minutes.*

Please note: In the case of a severe allergy to bee stings, the provider will attempt to quickly remove the stinger by scraping with a fingernail or other object.

Physician's Signature:______________________________ Date:______________________

EMERGENCY PHONE NUMBERS

Parent/Guardian #1:____

Name | Home # | Work # | Other

Parent/Guardian #2:____

Name | Home # | Work # | Other

(see emergency form for alternate if parents are unavailable)

Primary Health Provider's Name:______________________________ **Emergency Phone:**______________________

Please complete other side.

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TO BE COMPLETED BY CHILD CARE PROVIDER

Where in the program will the child receive care when a reaction occurs?____________________

Who will take charge of the situation?____________________

What will the staff do if the child is in the classroom?____________________

…on the playground?____________________

...on a field trip?____________________

Where will the medications for a reaction be kept?____________________

...while on a field trip?____________________

Who will call 911?____________________

Who will call the parents/guardian?____________________

Who will go with the child to the hospital and stay until the parents can assume responsibility?____________________

Who will care for the other children if the caregiver must take the allergic child away from the group? Is

the allergy **with** the child's picture prominently posted eating area? **Yes** **No**

I give permission to follow this plan of care prescribed by the physician. I also give my permission to call the health care provider listed for any additional medical information about my child. I understand that a photo of my child, including my child's name, specific allergies and treatment will be posted.

Parent/Guardian Signature: ____________________ Date: ___/___/___

TRAINED CHILD CARE PROVIDERS:

1. ____________________ Room:____________________
2. ____________________ Room:____________________

Plan of care reviewed by:

Director:____________________ Date: ___/___/___

Teacher:____________________ Date: ___/___/___

Child Care Health Consultant:____________________ Date: ___/___/___

Projected date of plan of re-evaluation (every six months or sooner if needed): **Date: ___/___/___**